TERRELL CLINIC

COSMETIC SURGERY • AESTHETICS • LIFESTYLE MEDICINE

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PATIENT SKINCARE HISTORY

Name:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Date of Birth: _____/_____/_____ E-mail:_____

Physician:_____Referred by:_____

Are you interested in a complimentary consultation with one of our dieticians or massage therapists? ____Yes ____No

What do you want to improve about your skin?_____

_____

Health History:
What are you allergic to?_____

Do you have any health conditions? _____

_____

Are you currently taking any medications?	____Yes ____No
If Yes, what kind?_____	
Do you smoke?	____Yes ____No
Do you consume alcohol regularly?	____Yes ____No
Are you pregnant or breastfeeding?	____Yes ____No
Do you wear contact lenses?	____Yes ____No
Do you have permanent makeup?	____Yes ____No
Do you tan in tanning booths currently?	____Yes ____No
Do you currently have a sunburn or windburn?	____Yes ____No
Do you develop cold sores/fever blisters?	____Yes ____No

Skin History:

Do you suffer from redness on the face?	____Yes ____No
Do you suffer from Acne?	____Yes ____No
Is your skin Dry?	____Yes ____No

Is your skin oily? ___Yes ___No
Do you have hyperpigmentation? ___Yes ___No
Are you sensitive to alcohol based products? ___Yes ___No
Do you currently use or receive any depilatories or waxing? ___Yes ___No
Are you applying any topical medications at this time? ___Yes ___No
What are they?_____
Are you currently using any topical Retinoid prescriptions? ___Yes ___No
What strength?_____How long?_____
Are you currently using Accutane? ___Yes ___No
How long?_____
Have you ever used any products that caused a negative reaction? ___Yes ___No
What was it and what was your reaction?_____
_____
Have you recently had laser resurfacing? ___Yes ___No
Have you recently had facial surgery? ___Yes ___No
Do you have regular collagen, Botox, or dermal filler injections? ___Yes ___No
Have you had a chemical peel or any other facial treatments? ___Yes ___No
When? _____

What skincare products do you use currently? _____

What is your daily care regimen? _____
_____
Do you consider your skin ___Sensitive ___Resilient ___Unsure
Describe your skin and check all that apply:

___Thick	___Thin	___Saggy	___Firm
___Normal	___Dry	___T-Zone/Combination	___Oily
___Acne	___Blackheads	___Malia	___Cysts
___Breakouts	___Acne-Scarred	___Large Pore	___Small Pore
___Florid	___Rosacea	___Eczema	___Freckled
___Mature	___Sun-Damaged	___Uneven/Blotchy	___Wrinkled
___Patchy Dryness	___Sallow	___Melasma	___Psoriasis
___Hyperpigmentation	___Dehydrated	___Broken Capillaries	___Tired

	Yes	No	N/A	Date
Recent Sun Exposure	X	X	X	_____
Previous Laser Treatments	X	X	X	_____
Hair Removal				
Waxing, Plucking, Electrolysis	X	X	X	_____
Accutane, last 6 months	X	X	X	_____
Gold Therapy	X	X	X	_____
Coagulopathies	X	X	X	_____
Herpes/Cold Sores	X	X	X	_____
Vitiligo	X	X	X	_____
History Melanoma	X	X	X	_____
Keloids/Hypertrophic Scarring	X	X	X	_____
Tattoos/Permanent Make-up	X	X	X	_____
Fillers, Botox, etc.	X	X	X	_____
Pacemaker/Defibrillator	X	X	X	_____
Implants/Surgeries treatment area	X	X	X	_____
Decreased sensation/Numbness in treatment area	X	X	X	_____

GENETIC DISPOSITION

Your Eye Color:
Light Blue 0 _____
Green 1 _____
Blue (medium to dark) 2 _____
Brown 3 _____
Brownish Black 4 _____

Your Natural Hair Color:
Red 0 _____
Blond 1 _____
Dark Blond / Chestnut 2 _____
Brown 3 _____
Black 4 _____

Color of Your Non-Exposed Skin:
Reddish 0 _____
Very Pale 1 _____
Pale with Beige Tint 2 _____
Light Brown 3 _____
Dark Brown 4 _____

Do You Have Freckles On Unexposed Areas?
Many 0 _____
Several 1 _____
Few 2 _____
Incidental 3 _____
None 4 _____

REACTION TO SUN EXPOSURE

What Happens When You Stay Too Long In The Sun?
Painful Redness, Blistering 0 _____
Moderate Burn, Sometimes Blister 1 _____
Mild Burn then Peel 2 _____
Rarely Burn 3 _____
Never Burn 4 _____

To What Degree Do You Turn Brown?
Not At All 0 _____
Hardly to Light Tan 1 _____
Medium Tan 2 _____
Tan Very Easily 3 _____
Turn Dark Brown Quickly 4 _____

Do You Turn Brown Within Several Hour of Sun Exposure?
Never 0 _____
Seldom 1 _____
Sometimes 2 _____
Often 3 _____
Always 4 _____

How Does Your Face React to the Sun?
Very Sensitive 0 _____
Sensitive 1 _____
Normal 2 _____
Very Resistant 3 _____

No Reaction 4 _____

TANNING HABITS & RECENT SUN EXPOSURE

When Did You Last Expose Your Skin to the Sun or an Artificial Tanning Source?
More Than Three Months Ago 0 _____
2 – 3 Months Ago 1 _____
1 – 2 Months Ago 2 _____
Less than 1 Month Ago 3 _____
Less than 2 Weeks Ago 4 _____

Do You Expose the Skin Areas to be Treated by the Sun?
Never 0 _____
Hardly Ever 1 _____
Sometimes 2 _____
Often 3 _____
Always 4 _____

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that facials should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be constructed as such. Because certain treatments should not be preformed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the esthetician's/therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks made by me will result in immediate termination of the session. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial/body treatments are contraindicated.

Patient Signature:_____ Date _____

Witness:_____ Date _____

For Staff Use Only:
Record the Total Score from each section:
TOTAL SCORE FOR GENETIC DISPOSITION: _____
TOTAL SCORE FOR REACTION TO SUN EXPOSURE: _____
TOTAL SCORE FOR TANNING HABITS: _____
SKIN TYPE SCORE _____

Patient's Fitzpatrick Skin Type:
Skin Type Score Fitzpatrick Skin Type

0 – 7	**1**
8 – 16	**2**
17 – 25	**3**
26 – 30	**4**
over 30	**5**

Initial:
_____ Benefits of procedure discussed
_____ Contraindications reviewed
_____ Risks reviewed
_____ Probability of success reviewed
_____ Alternative procedures available
_____ Consent signed
_____ Verbal and written post-treatment instructions given to patient
_____ Pre-op photos taken